County Approver Certification Form

For Access to the Department of Health Care Services **Cost and Financial Reporting System (CFRS).**

County Name: _____

To ensure the confidentiality of county mental health data, the Department of Health Care Services, requests the county Behavioral Health Director designate **two contacts** to be responsible for approving county staff requests for access to the confidential data in CFRS system.

Please complete the information below and email the signed form to MedCCC@dhcs.ca.gov. The email must be sent from the signer's (Behavioral Health Director's) email account. If you have any questions, please email MedCCC@dhcs.ca.gov.

Approver 1:

First Name: _____ Last Name: _____

Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Signature: _____ Date: _____

Approver 2:

First Name: _____ Last Name: _____

Title: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Signature: _____ Date: _____

County Behavioral Health Director Certification:

I, the undersigned designate the above county individuals to have independent authority to approve access requests to the **Cost and Financial Reporting System (CFRS).** DHCS may rely on approvals, denials, and changes made by the above individuals in its processing of access requests to this county's data. As changes occur to the above approving county contacts, I will sign an updated certification and forward it to DHCS.

By submitting this form, any previous approvers will be deleted.

County Behavioral Health Director Signature	Date
County Behavioral Health Director Name	County Behavioral Health Director Email Address